Dental Plans Comparison Chart

	SAFEGUARD	DELTACARE	DELTA DENTAL PLAN		
			PREFERRED PROVIDER OPTION (PPO)	IN-NETWORK	OUT-OF-NETWORK
Type of Plan	An HMO-style dental plan	An HMO-style dental plan	A dental plan that offers two provider networks and out-of-network benefits		
Annual Deductible	None	None	None	$50/person; $150/family	$50/person; $150/family
Annual Maximum Benefit	None	None	$1,750/person	$1,750/person	$1,750/person
COVERED SERVICES PREVENTIVE CARE					
Cleaning	100% (two every 12 months)	100% (two every 12 months)	100% (two/calendar year)	85% of covered charges (no deductible on first two cleanings/calendar year)	85% of R&C (no deductible on first two cleanings/calendar year)
Exam	100%	100%	100% (two/calendar year)	85% of covered charges (two/calendar year)	85% of R&C (two/calendar year)
Full Mouth X-Rays	100% (one every 24 months)	100% (one every 24 months)	100% (one every five years)	85% of covered charges (one every five years)	85% of R&C (one every five years)
BASIC SERVICES					
Emergency Treatment	$5 copay	$5 copay	100% of covered charges	85% of covered charges	85% of R&C
Extractions	100% (except $50 copay for bony impactions)	100% (except $50 copay for bony impactions)	85% of covered charges	85% of covered charges	85% of R&C
Fillings	100%	100%	85% of covered charges	85% of covered charges	85% of R&C
General Anesthesia	$30 copay for medically necessary extractions only	$30 copay for medically necessary extractions only	85% of covered charges for oral surgery only	85% of covered charges for oral surgery only	85% of R&C for oral surgery only
Gingivectomy	$55 copay/quadrant	$55 copay/quadrant	85% of covered charges	85% of covered charges	85% of R&C
Root Canals	$45 copay/canal	$45 copay/canal	85% of covered charges	85% of covered charges	85% of R&C
MAJOR SERVICES					
Bridges	$60 copay/unit	$60 copay/unit	50% (once every five years)	50% (once every five years)	50% of R&C (once every five years)
Crowns	$60 copay/crown	$60 copay/crown	85% (once every five years)	85% (once every five years)	85% of R&C (once every five years)
Dentures	$70 copay/complete upper or lower denture	$70 copay/denture	50% (once every five years)	50% (once every five years)	50% of R&C (once every five years)
Orthodontia	$1,000 copay + $150 start-up fees	$1,150 copay + $350 start-up fees	50% ($1,200 lifetime maximum)	50% ($1,200 lifetime maximum)	50% ($1,200 lifetime maximum)
TMJ	Not covered	Not covered	Not covered	Not covered	Not covered

Contact Information

Contact	Phone Number	Fax Number	Web Site
BENEFIT SYSTEM			
Benefit Enrollment	888-822-0487	310-788-8775	www.mylacountybenefits.com
COUNTY DEPARTMENT OF HUMAN RESOURCES			
Benefits Hotline	213-388-9982	N/A	http://dhr.lacounty.info/
MEDICAL			
PacifiCare HMO	800-367-2660	N/A	www.healthyatcola.com
UnitedHealthcare Choice Plus PPO	800-367-2660	N/A	www.healthyatcola.com
Kaiser Permanente	800-464-4000	N/A	www.kp.org/countyofla
DENTAL			
SafeGuard	800-880-1800	N/A	www.safeguard.net
DeltaCare	800-422-4234	N/A	www.deltadentalins.com
Delta Dental	888-335-8227	N/A	www.deltadentalins.com
FLEXIBLE SPENDING ACCOUNTS			
Administrator (Ceridian)	866-300-2303	888-367-3305	www.mylacountybenefits.com
LIFE AND AD&D			
CIGNA Life	800-842-6635	N/A	www.cigna.com

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options

2011

medical and dental plans comparison chart

What's Inside

This benefits comparison chart provides you with an overview of your *Options* benefit medical and dental plans. It's been designed to help you choose the plans that are right for you and your family— either during annual enrollment or as a new hire — and also for future reference.

Take some time to also review the Enrollment Highlights Guide and Personalized Enrollment Worksheet you received with this comparison chart for descriptions of your benefit plan options, information about premium rates and the *Options* monthly benefit allowance.

Once you've chosen your plans for 2011, you should save this comparison chart so you can refer to it throughout the year.

Remember, information about your *Options* benefit plans is also available online 24 hours a day, seven days a week using **mylacountybenefits.com**.

This comparison chart provides a general overview of the Options benefit medical and dental plans. It is provided for your convenience and is not intended to be detailed or comprehensive. Additional details about your benefits are available in other official plan documents, including official summary plan descriptions. To request a copy of an official plan document, contact the plan's customer service department directly. Contact information can be found on the back page of this comparison chart.

2011 *Options* Medical and Dental Plans Comparison Chart

Medical Plans Comparison Chart

	KAISER	PACIFICARE HMO	UNITEDHEALTHCARE CHOICE PLUS PPO	
			IN-NETWORK	OUT-OF-NETWORK
Type of Plan	A group model HMO with its own hospitals, outpatient facilities, staff physicians, nurses and other health care professionals	An HMO that contracts with private hospitals, medical groups and individual private practice physicians for services at negotiated rates	A medical plan that allows you to choose an in-network PPO provider or an out-of-network provider each time you need care	
Annual Deductible	None	None	$300/person $1,500/family	$1,500/person $3,000/family
Annual Out-of-Pocket Maximum	$1,500/person $3,000/family	$1,000/person $2,000/family	$5,000/person $15,000/family	$15,000/person $45,000/family
			excludes deductible/combined in- and out-of-network	
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	
PREVENTIVE CARE				**PREVENTIVE CARE**
Immunizations	No charge	No charge	No charge	No charge for covered amounts
Periodic Health Evaluations	No charge	No charge	No charge	No charge for covered amounts
MEDICALLY NECESSARY CARE				**MEDICALLY NECESSARY CARE**
Ambulance	No charge if medically necessary	No charge if medically necessary	20% copay after deductible	20% copay after deductible
Doctor Office Visit	$10 copay/visit; no charge pediatric visit to age 5	$10 copay/visit; no charge pediatric visit to age 5	20% copay, no deductible	50% copay after deductible
Emergency Room	$50 copay; waived if admitted (see plan booklet for a description of emergency services)	$50 copay (waived if admitted)	20% copay after deductible (waived if admitted)	50% copay after deductible (waived if admitted)
Hospital Care	No charge	No charge	20% copay after deductible	50% copay after deductible
Maternity	$10 copay for office visit to confirm pregnancy; no charge thereafter	No charge	20% copay after deductible	50% copay after deductible
Surgery	Inpatient: No charge Outpatient: $10 copay	No charge	20% copay after deductible	50% copay after deductible
X-Ray & Lab Tests	No charge	No charge	20% copay, no deductible	50% copay after deductible
Prescription Drugs	$5 copay generic and $20 copay brand name for up to 100-day supply for each medication prescribed by a Kaiser physician or any dentist and filled at a Kaiser pharmacy Sexual dysfunction drugs: 50% co-pay (limitations apply)	Pharmacy: $5 copay generic; $20 copay brand name (30-day supply) Mail order: $10 copay generic; $40 copay brand name (90-day supply) Sexual dysfunction drugs: 50% copay (limitations apply)	Pharmacy: $5 copay Tier 1; $20 copay Tier 2; $35 copay Tier 3 (31-day supply) Mail order: $10 copay Tier 1; $40 copay Tier 2; $70 copay Tier 3 (90-day supply). Sexual dysfunction drugs: 50% copay (limitations apply)	Not covered
MENTAL HEALTH CARE				**MENTAL HEALTH CARE**
Hospital Inpatient Care	No charge	No charge	20% copay after deductible	50% copay after deductible
Hospital Outpatient Care	$10 copay/visit	$10 copay/visit	20% copay after deductible for covered charges	50% copay after deductible for covered charges
OTHER PLAN BENEFITS				**OTHER PLAN BENEFITS**
Home Health Care	No charge within Kaiser area (up to 2 hours/visit; 3 visits/day; 100 visits/calendar year)	$10 copay	20% copay/visit after deductible preauthorization required	50% copay after deductible preauthorization required
			(up to 100 visits/calendar year; combined in- and out-of-network)	
Hospice Care	No charge	No charge	20% copay after deductible	50% copay after deductible
Physical Therapy	$10 copay/visit	$10 copay/visit	20% copay, no deducitble	Not covered
Skilled Nursing Facility	No charge (up to 100 days/benefit period)	No charge (up to 100 days/condition)	20% copay after deductible	50% copay after deductible
			(up to 30 non-consecutive days/condition; combined in- and out-of-network)	
Vision Care	No charge for refraction exam; does not cover glasses	$10 copay for eye exam (1 every 12 months) $10 copay for lenses and frames (1 pair every 24 months)	$10 copay for eye exam (1 every 12 months) $10 copay for lenses & frames (1 pair every 24 months), no deductible	Coverage limited to reimbursement provided under VSP out-of-network schedule

Important Note: The County believes each of these plans is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Benefits Hotline at 1-213-388-9982. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov and www.healthcare.gov.

Indicates Plan Changes

This chart is printed on recycled paper to support the County's commitment to the environment.